Family Needs Assessment

Name: _____ DOB: _____ Medicaid Number: _____

Site of assessment ☐Home ☐Clinic ☐Other, specify: _____

If not in home, explain why: _____

Is this a migrant family? ☐Yes **if yes, must complete CPW-02A** ☐No

Names of Household Members	Relationship to Client	DOB	Names of Household Members	Relationship to Client	DOB

Indicate other household members receiving case management services with an *

AGENCIES INVOLVED WITH CLIENT/FAMILY					
Agency/Program	**Involved with family?**	**Client/ Family Member**	**Status Referred/ Applied/Waiting**	**Client Program ID Number**	**Contact Person/Phone Number**
SSI	☐**YES** ☐**NO**				
CSHCN	☐**YES** ☐**NO**				
MH/MR	☐**YES** ☐**NO**				
TCB	☐**YES** ☐**NO**				
WIC	☐**YES** ☐**NO**				
DHS-Food Stamps, TANF	☐**YES** ☐**NO**				
OAG Child Support Division	☐**YES** ☐**NO**				
TDPRS	☐**YES** ☐**NO**				
CBA/HCS/ CLASS/MDCP	☐**YES** ☐**NO**				
Other Agencies					

HEALTH STATUS --CLIENT	
HEALTH CONDITION/RISK and describe how it impacts client's life	
Medications ☐ None	
Nutrition ☐ No concerns	
Medical/Adaptive Equipment and Supplies ☐ No need	

☐ Referral(s) needed _____

HEALTH MEDICAL PROVIDERS -- CLIENT			
	PROVIDER NAME	**ADDRESS/PHONE**	**FUTURE APPOINTMENTS**
PCP/Medical Home			
OB/GYN Due date: _____ Exams current ☐ Yes ☐ No ☐ **N/A**			
THSteps/Well-Child Exams, **Current ☐ Yes ☐ No** ☐ **N/A completed by PCP** ☐ **N/A client over 21 years old**			
Dentist **exams current ☐ Yes ☐ No**			
Physician/Specialist other than PCP ☐ **N/A no specialist**			
Immunizations (if not PCP) **Current ☐ Yes ☐ No**			
Pharmacy			

Client Name _____ Client Medicaid Number _____

HEALTH MEDICAL PROVIDERS -- CLIENT			
	PROVIDER NAME	**ADDRESS/PHONE**	**FUTURE APPOINTMENTS**
Hospital			
DME/Medical & Adaptive Equipment Supplier ☐ **N/A no DME or supplies**			
Managed Care/HMO/Other Medical Insurance ☐ **No Medicaid Managed Care** ☐ **N/A no other insurance**			

☐ Referral(s) needed _____

DEVELOPMENTAL/REHABILITATIVE -- CLIENT	
Motor Skills ☐ No concerns	
Vision ☐ No concerns	
Speech/Language ☐ No concerns	
Hearing ☐ No concerns	
Self Help Skills (feeding, dressing, other activities of daily living {ADLs}) ☐ No concerns	
OT and/or PT ☐ No concerns	
Peer Relationships ☐ No concerns	
Mental Health/ Emotional/Behavioral ☐ No concerns	

☐ Referral needed _____

Client Name _____ Client Medicaid Number _____

EDUCATIONAL/VOCATIONAL -- CLIENT		
ECI ☐ N/A client is over 3 yrs. old	ECI services being provided	If not currently served is referral appropriate? ☐ Yes ☐ No
Head Start ☐ N/A client is over 5 yrs. old	program attending	If not currently enrolled is referral appropriate? ☐ Yes ☐ No
School Services ☐ N/A client not school age ☐ N/A client has diploma/ GED	school attending/grade level	special education ☐ Yes ☐ No
	concerns at school	concerns with ARD/ transition process
Vocational ☐ N/A client under 16		
Other Educational/Vocational Concerns ☐ None		

☐ Referral(s) needed _____

HEALTH STATUS -- FAMILY MEMBERS	
Medical ☐ No unmet needs	
Dental ☐ No unmet needs	
Other ☐ No unmet needs	

☐ Referral(s) needed _____

SOCIOECONOMIC -- FAMILY	
Financial Concerns ☐ No unmet needs	
Employment ☐ No unmet needs	
Educational ☐ No unmet needs	

Client Name _____ Client Medicaid Number _____

SOCIOECONOMIC -- FAMILY	
Utilities ☐ No unmet needs	
Food ☐ No unmet needs	
Other Concerns ☐ No unmet needs	

☐ Referral(s) needed _____

HOUSING -- FAMILY	
Housing Concerns ☐ No unmet needs	
Accessibility Concerns ☐ No unmet needs	
Repairs Needed ☐ No unmet needs	
Plan for Power Outage ☐ No unmet needs	
Safety/Environmental Issues ☐ No unmet needs	
Fire Escape Plan ☐ No unmet needs	

☐ Referral(s) needed _____

TRANSPORTATION –FAMILY	
Understands/Uses Medical Transportation Services ☐ No unmet needs	
Personal Transportation/Safety/ Reliability/Access ☐ No unmet needs	

☐ Referral(s) needed _____

Client Name _____ Client Medicaid Number _____

PSYCHOSOCIAL STRENGTHS/ISSUES -- FAMILY	
Marital ☐ No unmet needs	
Legal Issues/Child Support ☐ No unmet needs	
Parenting ☐ No unmet needs	
Community/Family Support Systems ☐ No unmet needs	
Child Care ☐ No unmet needs	
Respite Care ☐ No unmet needs	
Cultural Issues ☐ No unmet needs	
Mental Health/Emotional/ Psychological/Counseling ☐ No unmet needs	
Family Violence ☐ No unmet needs	
Substance Abuse ☐ No unmet needs	
Other Psychosocial Concerns ☐ None	

☐ Referral(s) needed _____

Additional Comments: _____

_____

_____

_____

_____

Case manager signature: _____ Date: _____

Case manager printed name: _____

Client Name _____ Client Medicaid Number _____